Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: TEXAS HEALTH CENTER P.A. 4804 N. NAVARRO VICTORIA, TX 77904	MFDR Tracking #: M4-10-3411-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: WAL MART ASSOCIATES INC Box #: 53	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: ""Rule 134.202. Due to added responsibilities in the workers' compensation {sic} it is appropriate that the evaluation and management codes be upgraded to a higher level of reimbursement. This patient was seen at a hospital at the time of his injury. The doctor has the added responsibility of reviewing notes from other providers in order to research compensability."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $129.19

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: ""Please note that the office visit for procedure 99214 does not support the level of service billed. It requires at least 2 of these 3 key components. A detailed history, a detailed examination, medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family. The notes do not appear to have 2 of 3 components mentioned above and therefore, no additional payment is recommended at this time."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
10/27/09	99214-25	N/A	$129.19	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services after March 1, 2008 and applies to the services in this dispute.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 11/16/2009

   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 589 – The documentation received does not support the level of service billed. Please adjust the level of service billed or provide additional documentation to support the service billed.

   Explanation of benefits dated 12/7/2009

   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct, therefore no additional allowance appears to be warranted.
   - 5081 – Reduction or denial of payment resulting after a reconsideration was completed.

Issues

1. Does the medical documentation provided support the services billed under CPT code 99214?
2. Is the Requestor entitled to reimbursement?

Findings

1. The Requestor billed Current Procedural Terminology (CPT) code 99214 with an appended -25 modifier. The description of this code is as follows: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history, a detailed examination and a medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family. The description of the -25 modifier is: Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.
2. Pursuant to 134.203(a)(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
3. The documentation submitted consists of handwritten notes and does not contain a legible signature as is required by Medicare. Pursuant to rule 133.210(b) when submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents. The documentation submitted does not support the requirement for billing of CPT code 99214-25 in accordance to Rule 134.203.

Conclusion

For the reasons stated above, the division finds that the Requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

		4/22/10
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.